Dental Services – Package 1 (DHMO)

NOTE: ***All Health Net Seniority Plus members have Medicare covered Dental benefits. Only Health Net members who have purchased the Optional Supplemental Benefit Package 1 have non-Medicare covered preventive and comprehensive Dental HMO benefits. Please see Section 4 under "Extra benefits you can buy (these are called "optional supplemental benefits")" for copayment and benefit information***

Health Net Dental arranges for dental services by contracting with Contracted Dentists to provide services to our Members. We encourage Members to take an active role to ensure good dental health, and recommend scheduling a first appointment with a Primary Care General Dentist within 120 days of enrollment. This will allow any conditions to be found and treated.

All services must be provided by a Contracted Dentist to be covered under this plan. Most covered services will be available from and provided by your selected Primary Care General Dentist. Exceptions are described in the sections, Referrals to Specialty Care Dentists and Emergency Dental Care. Please refer to the current Health Net Dental Directory for a listing of available Primary Care General Dentists.

In the event of an emergency, please follow the guidelines in the section, Emergency Dental Care. You may also call Health Net Dental at **1-800-880-8113** for assistance in necessary procedures.

This section will help you understand the dental plan benefits. It provides a description of the dental copayment requirements, exclusions, limitations, and benefits of this plan. Read this section and keep it readily available for reference when you decide to use the services available through this plan. In the event of an emergency, please follow the guidelines in the section called "Emergency Dental Care".

For assistance in the necessary emergency procedures or if you have questions about the dental benefits, copayments, limitations, or exclusions, you may call the Customer Service Department of Health Net Dental at **1-800-880-8113** (TDD/TTY **1-800-880-3165**), Monday-Friday, 6:00 a.m. to 6:00 p.m. Interpreter Services are also available by calling our Customer Service Department.

Choosing Your Primary Care Dentist

Members must choose a Primary Care General Dentist from the Health Net Dental Directory. Health Net Dental's Customer Service Department is available to provide assistance in the selection of a Primary Care General Dentist. We request that a selection of dentist be made within the first 30 days of coverage. If a Primary Care General Dentist is not chosen, Health Net Dental will assign one that is near your residence.

Except as specified below, Covered Services must be provided by the Member's Primary Care General Dentist in order to be covered under this dental plan. Health Net Dental does not cover services and supplies provided by a dentist who is not the Member's Primary Care General Dentist, except as specifically described under the following two sections titled Emergency and Urgent Care Services and Referrals to Specialists in this section. The Member's Primary Care General Dentist

must obtain approval from Health Net Dental prior to the referral of a Member to a specialist. This dental plan does not cover services and supplies provided by non-physician/dentist healthcare practitioners.

Referrals To Specialty Care Dentists

Please refer to Section 4 of the Evidence of Coverage to see what care is covered under this dental plan.

A Member's Primary Care General Dentist has primary responsibility for your dental care. When specialty dental care is needed, your Primary Care General Dentist will submit a request to Health Net Dental for treatment authorization. When treatment is authorized, the dental copayments listed in the Schedule of Benefits will apply. If treatment is not authorized, you will receive a denial notice telling you the reason for the denial and explaining your right to appeal the decision (request a reconsideration). For more information, please refer to the Evidence of Coverage. Your coverage must be in effect when each procedure is started to be considered covered under this plan. This includes referrals for Orthodontic Care.

Emergency Dental Care

Emergency and Urgent Dental Care Services are "Medically Necessary" services to relieve severe pain or other symptoms. It may also be needed to diagnose and treat a sudden illness that a reasonable person in the same situation would believe it could lead to a serious health threat or impair their health if not treated right away. Emergency dental services and care as defined in the California Health & Safety Code means a screening, examination, and evaluation to determine if an emergency medical condition exists.

What Do You Do When You Require Emergency Dental Care Or Urgently Needed Services

If a Member needs Emergency Dental Care, he/she should immediately contact his/her selected Primary Care General Dentist for an appointment. All contracted dentists will have Emergency Dental Care available 24 hours a day, 7 days a week. If the Primary Care General Dentist is not available, Member may seek Emergency Dental Care from any licensed dentist. Members may also contact the Customer Service Department of Health Net Dental at **1-800-880-8113** (TDD/TTY **1-800-880-3165**), Monday-Friday, 6:00 a.m. to 6:00 p.m. Interpreter Services are available by calling our Customer Service Department.

Services provided by a dentist other than the Primary Care General Dentist will be covered only when it is shown that the:

- Member was not able to get services from their Primary Care General Dentist.
- Services were for Emergency Dental Care.
- Services were Medically Necessary.
- Services are listed as covered benefits under this plan.
- The Member must pay any dental copayments. If the above conditions are not met, the Member will need to pay all billed charges at the dentist's Usual and Customary Reasonable Fee (UCR).

- If the Member is outside the Service Area or more than 35 miles from his or her Primary Care General Dentist, the Member may receive Emergency and Urgent Dental Care Services from any licensed dentist. Please follow the rules under Reimbursement for Emergency Dental Care below.

Transition Of Care For New Members

This is a summary of our policy on Transition of Care. You may call Health Net Dental's Customer Services Department to request a formal copy.

New Members who are getting treatment for an Acute* condition with a non-Contracted Dentist should call the Customer Service Department of Health Net Dental at **1-800-880-8113** (TDD/TTY **1-800-880-3165**), Monday-Friday, 6:00 a.m. to 6:00 p.m. Interpreter Services are available by calling our Customer Service Department. Your specific situation will be reviewed to determine if you can continue treatment with that dentist or if care should be continued with a Contracted Dentist.

Read the section, Emergency and Urgent Care Services. It lists the situations in which Emergency Dental Care for Acute dental conditions may be given by a non-Contracted Dentist.

*An Acute dental condition is defined as Medically Necessary for any urgent condition that requires:

- Relief for severe pain or bleeding.
- Getting rid of an acute infection.
- Treatment of an injury of the teeth that is needed right away.

Transitional Care Limitations

The decision to approve transitional care for an Acute condition lies with Health Net Dental. It will only be covered when approved by Health Net Dental.

- Health Net Dental will approve transitional care with a non-Contracted Provider only until it is appropriate to have the Member receive care with a Contracted Dentist.
- Health Net Dental will not cover services or provide benefits that are not covered under the terms and conditions of Evidence of Coverage.
- Health Net Dental will not cover services or provide benefits that are covered by a prior dental plan.
- Health Net Dental may ask that the non-Contracted Dentist meet the same contractual terms and conditions as those asked of our Contracted Dentists.
- Health Net Dental will not be liable for actions resulting from the negligence, malpractice, or other wrongful acts as a result of transition of care services provided by a non-Contracted Dentist.

Health Net of California, Inc. contracts with Medicare each year, this benefit may not be available next year.

Second Opinions

This is a summary of our policy on Second Opinions. A formal copy is available from our Customer Service Department.

Health Net Dental Members may request a second opinion for proposed or completed treatment. Should Health Net Dental request a Member seek a second opinion for any reason, Health Net Dental will pay for all necessary charges, including the dental copayment.

A Member may request a second opinion if:

- You question or do not agree with the reasonableness, necessity, diagnosis and/or treatment plan chosen by your Primary Care General Dentist;
- If you are not happy with the progress or result of treatment you received from a provider;
- The clinical indications are not clear or a diagnosis is in doubt, or:
- The Primary Care General Dentist is unable to diagnose the condition.

You must call Health Net Dental's Customer Service Department to receive approval for a second opinion. If a second opinion is authorized, you will be referred to a Contracted Dentist. An exception to this policy may be made if a Contracted Dentist is not available in your area. The second opinion dentist shall be licensed, acting within his or her scope of practice, possess an appropriate clinical background, including training and expertise related to dental care. When you ask for a Second Opinion, you will be financially responsible for any applicable dental copayments shown in the Schedule of Benefits. Charges for second opinions that are not approved by Health Net Dental are not covered under this plan.

If the request for a second opinion is denied, you will be notified in writing of the reason for the denial. The notice will tell you why the second opinion was denied, and explain how you may request a reconsideration under the appeal procedures described in the Evidence of Coverage.

Utilization Review
Health Net Dental reviews treatment patterns and certain courses of treatment to determine appropriateness. Health Net Dental uses guidelines and set criteria during the review process. These guidelines and certain criteria are available upon request.

Customer Services Department 1-800-880-8113 (TDD/TTY 1-800-880-3165)

Health Net Dental's Customer Service Department is available during normal business hours to provide assistance with your dental plan. Normal business hours are Monday – Friday, 6:00 a.m. to 6:00 p.m. We are just a toll-free call away. We can provide assistance with questions, explain your dental benefits, dental office selections/transfers, specialty care referrals, second opinions, ID cards, complaints or other matters. We can also provide assistance to Members who need the services of an interpreter. Interpreter services are available during normal business hours by calling **1-800-880-8113**. TDD/TTY services are available during normal business hours at **1-800-880-3165**.

Dental Copayments

For Covered Benefits/Services you will be responsible for the fees "copayments" listed later in the Benefits section. dental copayments are paid by the Member to the Contracted Dentist (Primary Care General Dentist or Specialty Care Dentist) at the time care is received. You are responsible for the cost of any service received that is not specifically listed as a Covered Benefit. *Members are not responsible for payments owed to Contracted Dentists by Health Net Dental.*

Coordination Of Benefits

When a Member has coverage under this plan and any Other Plan, coverage under this plan is coordinated with the benefits of the Other Plan. This means that when added together, the two coverages will not provide benefits more than the fees charged. Health Net Dental reserves the right to be reimbursed from any Other Plan for the value of the services provided. Members must give this payment to Health Net Dental or any of its Contracted Dentists. In the Coordination of Benefits with any Other Plan, Health Net Dental uses the guidelines for determining primary carrier and secondary carrier responsibility in accordance with the California Knox-Keene Health Care Service Plan Act of 1975 and its regulations.

Member's Liability For Payment

Members are responsible for any applicable dental copayments and for payment for non-Covered Services or benefits in excess of specified limitations under the Principal Limitations of Benefits and Principal Exclusions sections. If Health Net Dental does not pay a Contracted Dentist for Covered Services, the Member will not be liable to the dentist for any sums owed by Health Net Dental. But if Health Net Dental does not pay a non-Contracted Dentist, the Member may be liable for payment. If a member receives non-Emergency Dental Care from other than the Member's Primary Care General Dentist, the Member will be responsible for payment, except for instances in which the care provided is an out-of-area emergency.

Termination Of Contracted Dentist Contract

Upon termination of any Contracted Dentist contract, Health Net Dental shall be liable for payment of Covered Services rendered by such provider (other than any dental Copayment) to a Member who retains eligibility under the Agreement or by operation of law, who is under the care of such provider at the time of such termination, until the Covered Services being rendered to the Member by such provider are completed, unless Health Net Dental makes reasonable and Medically appropriate provision for the assumption of such services by another Contracted Dentist. The Member may elect to continue care with the dentist (if the Dentist Agreement was terminated by the Plan) if care was for an acute or serious chronic condition. If a Member has questions about or wishes to request continuity of care, he or she should contact Health Net Dental's Customer Service Department.

Independent Contractor Relationship

The relationship between Health Net Dental and Contracted Dentists is that of independent contractors. The Contracted Dentists are independent, community-based practitioners and professional corporations licensed to provide dental services. Although Health Net Dental periodically monitors aspects of the services rendered by Contracted Dentists, the Contracted Dentists are not agents or Employees of Health Net Dental, and Health Net Dental and its Employees and agents are not Employees or agents of any Contracted Dentist. Contracted Dentists maintain the Dentist-Patient relationship with Members and are solely responsible to Members for all of the services they provide

to Members. No joint venture, partnership, employment, agency, or other relationships are created by the Evidence of Coverage or Agreement.

Dental Malpractice

Health Net Dental and Contracted Dentists are independent entities who have entered into contracts with each other for the purpose of making dental services available to Health Net Dental members, while non-Contracted Dentists may not have relationships with Health Net Dental. Any dispute alleging the medical malpractice, negligence and/or wrongful act of any dentist, shall not include Health Net Dental and shall include only the provider subject to the allegation.

Third Party Liability

If a Member is injured through the actions of another person (a third party), Health Net Dental will provide benefits for all Covered Services that are received from Contracted Dentists, as well as Emergency Dental Care as described in this Evidence of Coverage. However, if the Member receives money because of the injuries, the Member must reimburse Health Net Dental for the value of any services provided through this plan.

If the Member is injured because of the actions of a third party and wishes to receive benefits under this plan, the Member must cooperate with Health Net Dental's efforts to obtain reimbursement, including telling Health Net Dental the name and address of the third party, if known, telling Health Net Dental the name and address of the Member's lawyer, if the Member is using a lawyer, and completing other paperwork that Health Net Dental may require. If the Member receives money because of the injuries sustained, and the Member has received benefits under this plan for those injuries, the Member must hold any money the Member receives in trust, and not use any of it until Health Net Dental is reimbursed for the value of the benefits that it provided.

Unless the Member receives monies from a Worker's Compensation claim, the amount that the Member is required to reimburse Health Net Dental, will be limited to one-third of the money that the Member receives if a lawyer was engaged, or one-half of the money that was received if the Member did not engage a lawyer. Hospitals or other parties may also have claims for reimbursement, which are separate from any claim of Health Net Dental.

Refusal Of Treatment

If a Member does not accept procedures or treatment recommended by a Contracted Dentist, the dentist may consider this refusal to accept his/her course of action as contrary to maintaining the dentist-patient relationship. The dentist may also consider it preventing the delivery of good dental care. If a Member refuses to accept such a recommended treatment or procedure, and the Contracted Dentist believes that no professionally acceptable treatment exists, the Member shall be notified. If the Member still refuses to accept the recommended treatment or procedure, then neither Health Net Dental nor any Contracted Dentist will have any further responsibility to provide care for the condition under treatment. A Member has the right to request alternative treatment or/services in this case that he/she believes is covered and to appeal requests that are denied. Please refer to the Evidence of Coverage for more information. The provisions of this section do not prevent a Member from changing Primary Care General Dentists upon proper notice to the Customer Service Department. The right of a legally competent adult patient to decide whether or not to submit to medical procedures necessarily includes, subject to certain limited exceptions, the right to refuse

drugs, treatment or other procedures. A general statement of the right to refuse treatment is set forth in Title 22, California Code of Regulations, Section 70707 (a.k.a. "Patient Bill of Rights").

Public Policy

Health Net Dental permits Members to participate in setting its public policy through its Public Policy Committee. For the purposes of this paragraph, "public policy" means acts performed by Health Net Dental and its Employees to assure the comfort, dignity and convenience of Members who rely on Contracted Dentists to provide Covered Services. Call Health Net Dental's Customer Service Department if you would like more information.

Right To Receive And Release Information

As a condition of enrollment in this dental plan, Health Net Dental, its agents, independent contractors, and Contracted Dentists shall be allowed to release to, or obtain from, any person, organization or government agency, any information and records, including patient records of Members, which Health Net Dental requires or is obligated to provide pursuant to legal process, federal, state or local law, or requires in the administration of this dental plan.

Regulations

Health Net Dental is subject to the requirements of the Act and its regulations. Any provisions that should be in this the Evidence of Coverage or Agreement, by either of the above legal sources, shall bind Health Net Dental whether or not they are in this Evidence of Coverage or Agreement.

Non-Assignability Of Benefits

The coverage and benefits of this plan may not be assigned without the prior written consent of Health Net Dental. This consent may be withheld for any reason. Health Net Dental reserves the right to make payment of Benefits, at its sole discretion, directly to the attending dentist or to the Member.

Health Net Dental Privacy Policy

Health Net Dental's privacy notice regarding its policies and procedures for preserving the confidentiality of medical records and Health Net Dental's use and disclosure of Protected Health Information is available to you. This notice is required by State and Federal Privacy laws including the Health Insurance Portability and Accountability (HIPAA) and will be furnished to you upon enrollment, upon request and upon material modification.

Fraud And Abuse

Health Net Dental has an anti-fraud program to investigate possible fraudulent or abusive issues. Members and Applicants may report a suspect issue to Health Net Dental and we will investigate it in confidence.

Fraud is a deception or misrepresentation by a provider, Member or any person acting on their behalf, with the knowledge that the deception or misrepresentation could result in some unauthorized benefit or payment. A false or fictitious claim may include, or be supported by, false or fictitious statements.

Some examples of fraud are:

- Submitting claims for services, supplies, or equipment not furnished to or used by Members.
- Billing or submitting a claim for non-Covered or non-chargeable services, supplies, equipment disguised as covered items.
- Providing services to an ineligible person and billing or submitting a claim for the services in the name of an eligible Member.
- Misrepresentation of dates, frequency, duration, or description or services rendered.

Abuse is an improper practice or misuse by a provider or Member that results in unnecessary costs or benefits. Abuse includes payments for services or supplies that are not Medically necessary or those that fail to meet professionally recognized standards.

Some examples of abuse are:

- A pattern of providing services that is not Medically necessary, or if Medically necessary, not to the extent rendered or provided.
- Care of inferior quality. For example, consistently furnishing dental services that do not meet accepted standards of care.
- Failure to maintain adequate clinical or financial records.
- Excessive use by a Member of controlled drugs (e.g. pain medications), sometimes achieved by using multiple providers.

To report a suspected fraud or abuse issue, Members and Applicants may call the Customer Service Department of Health Net Dental at **1-800-880-8113** (TDD/TTY **1-800-880-3165**), Monday-Friday, 6:00 a.m. to 6:00 p.m. Interpreter Services are available by calling our Customer Service Department.

Principal Dental Limitations of Benefits

Please refer to the Dental Covered Services Schedule to determine your copayment responsibility.

- Prophylaxis is limited to one every six consecutive months at no charge. Additional prophylaxis services will be at a copayment of $40 for adults (age 18 and older) and $25 for children (age 17 and under).
- Fluoride treatment is limited to once every twelve months for adults (age 18 and older) and children (age 17 and under).
- Bitewing x-rays are limited to one series of four films in any twelve consecutive months.
- Full mouth x-rays are limited to once every twenty-four consecutive months.
- Sealants are covered up to the fourteenth birthdate and are limited to permanent first and second molars only.
- Periodontal treatments (gingival curettage and root planing) are limited to four separate quadrants in any twelve consecutive months and no more than two quadrants per date of service.
- Periodontal maintenance procedure/ periodontal prophylaxis (including minor scaling) is limited to one time per six consecutive months following scaling and root planing (active therapy).
- Periodontal surgery (gingivectomy or osseous mucogingival) is limited to once per quadrant in any thirty-six consecutive months.
- A full or removable partial, upper/lower denture is not to exceed one each in any five-year period, and only if it is unsatisfactory and cannot be made satisfactory by either reline or repair.

- Replacement of a restoration is covered only when it is Dentally Necessary.
- Fixed partial dentures will be covered only when a removable partial denture cannot satisfactorily restore the case. If fixed partial dentures are used when a removable partial denture could satisfactorily restore the case, then the fixed partial denture is considered to be Optional Treatment.
- Full cast crowns, porcelain crowns, porcelain fused to metal or plastic processed to metal type crowns are not a benefit for children under 16 years of age. The Plan covers an acrylic or stainless steel crown.
- A crown placed on a specific tooth is covered only once in any five-year period and only if it cannot be repaired and restored to natural function. A maximum of five units of crown and removable partial dentures will be covered in any one arch, in accordance with the Plan's policies and procedures.
- Crown lengthening, in lieu of all other restorative treatment performed on the same tooth on the same day, is limited to one time per tooth per lifetime.
- Relining or rebasing of complete or immediate dentures, as Dentally Necessary, within six months of installation of the replacement denture is limited to one. After the initial six months, relining and rebasing is limited to one per arch per year at the applicable dental copayment.
- Pedodontic referral for children up to the sixth birthdate will be covered only after two attempts for treatment have been made by the Primary Dentist.
- Specialty referral benefits are limited to necessary endodontic, periodontic and oral surgery procedures that cannot be rendered by the assigned Primary Dentist.
- Consultation by a specialist for non-Covered Services is excluded.
- Stayplates are only a benefit to replace extracted anterior teeth for adults.
- Palliative (emergency) treatment of dental pain, considered for payment as a separate benefit only if no other services (except x-rays) are rendered during the visit.

Optional Treatment Provisions

If (1) a less expensive alternative procedure, service or course of treatment can be performed in place of the proposed treatment to correct a dental condition, as determined by the Plan; and (2) the alternate treatment will produce a professionally satisfactory result; then the maximum eligible dental expense to be considered for payment will be the less expensive treatment.

Principal Dental Exclusions

Payment will not be made for:

- Services to which the Member is entitled under any Workers' Compensation Law or Act or any other insurance plan, even if the Member did not claim those benefits.
- Procedures that are: (a) not Dentally Necessary; or are (b) not customarily recognized throughout the dentist's field of specialty as essential for the treatment of the condition; (c) for services that are not prescribed by the attending Contracted Dentist.
- Temporomandibular joint treatment (T.M.J.).
- Elective or cosmetic dentistry, except as listed in the Benefit Schedule as a Covered Service and performed by a Contracted Dentist. Benefits for resin-based composite restorations on posterior teeth (behind the second bicuspid) will be based on the allowance for the corresponding amalgam restoration.

- Oral surgery requiring the setting of fractures or dislocations. Orthognathic surgery or other oral surgical procedures solely for orthodontic purposes.
- Loss or theft of full or partial dentures or other dental appliances.
- Services including:
  (a) dispensing of drugs;
  (b) diagnostic photographs;
  (c) panoramic x-ray, except when used as part of a full mouth series in the Contracted Primary Dentist office only;
  (d) athletic mouthguards;
  (e) precision or semi-precision attachments;
  (f) denture duplication;
  (g) harmful habit appliances;
  (h) congenital or developmental malformations, including, but not limited to cleft palate, congenitally missing or supernumerary teeth;
  (i) a service not specifically listed as a covered benefit;
  (j) x-rays rendered at a specialist's office (except for authorized pedodontic referrals);
  (k) hospital charges of any kind.
- Oral surgical procedures involving:
  (a) recontouring of hard and soft tissues;
  (b) sinus exploration;
  (c) oral antral fistulas;
  (d) removal of foreign bodies;
  (e) salivary glands and ducts;
  (f) the removal or treatment of cysts, tumors, or neoplasms.
- Any procedure of implantation, reimplantation or related procedures.
- Procedures that are considered Experimental or investigative or that are not widely accepted as proven and effective within the organized dental community.
- General anesthesia, inhalation sedation, intravenous sedation, oral sedation drugs or intramuscular sedation.
- Treatment or consultations rendered by a specialist if:
  (a) a Member is deemed unmanageable for treatment by the Primary Dentist, except for children up to the sixth birthdate; or
  (b) treatment cannot be rendered by the Primary Dentist due to the medical condition or physical limitations of the Member; or
  (c) a consultation is for non-Covered Services.
- Dental expenses incurred under this dental plan that are in connection with any dental procedure started prior to the Member's effective date under this Plan or after termination of the Member's coverage.
- Procedures relating to:
  (a) bite analysis;
  (b) the correction of abrasion, erosion, or attrition;
  (c) the change of contact or contour;
  (d) restorations for the purpose of splinting (except when necessary in conjunction with periodontal treatment);
  (e) grafting;
  (f) the treatment of non-pathologic conditions; and

(g) overdentures and associated procedures.

- Services that, in the opinion of the Plan, do not have a reasonable, favorable prognosis.
- Disease contracted or injuries sustained as a result of a major disaster, war, declared or undeclared, epidemic conditions, or from exposure to nuclear energy, whether or not a result of war.
- Further liability for additional treatment on a tooth when the Member and provider have elected a treatment plan that is disallowed by the Plan. (Members may appeal denial.)
- Crowns, inlays or onlays for teeth that can be satisfactorily restored by other means that meet professionally recognized standards.
- All crowns and fixed or removable partial dentures for full mouth reconstruction, defined as treatment relating to:
  (a) the change of vertical dimension, or
  (b) the restoration of occlusion, or
  (c) extensive restorative treatment involving all remaining occluding teeth.
- A Contracted Dentist may refuse treatment to any Member who continually fails to follow a prescribed course of treatment.

Orthodontic Benefit Limitations and Exclusions

- Orthodontic benefits are available only at Contracted Orthodontic offices.
- If the Member relocates to an area and is unable to receive treatment with the original Contracted Orthodontist, coverage under this program ceases and it becomes the obligation of the Member to pay the Usual and Customary Reasonable Fee (UCR) of the orthodontist where the treatment is completed.
- Covered treatment cannot be transferred by the Member from one Contracted Orthodontist to another Contracted Orthodontist.
- No benefit will be paid for an orthodontic treatment program that began before the Member enrolled in the Orthodontic Plan.
- Plan benefits are limited to 24 months of usual and customary orthodontic treatment (Phase 2 treatment banding).
- If the Member becomes ineligible during the course of treatment, coverage under this program ceases and it becomes the obligation of the Member to pay the Usual and Customary Reasonable Fee (UCR) incurred for the entire remaining balance of treatment.
- Orthognatic surgery cases and cases involving cleft palate, micrognathia, macroglossia, hormonal imbalances, temporomandibular joint disorders (T.M.J.), or myofunctional therapy.
- Re-treatment of orthodontic cases, changes in treatment necessitated by an accident of any kind, and treatment due to neglect or non-cooperation are excluded.
- The following are not included in the orthodontic benefits and the orthodontist's usual and customary charges apply:
  (a) initial diagnostic work-up and x-rays
  (b) tracings and photographs
  (c) Phase 1 orthodontic treatment (prior to full mouth banding)
  (d) records; functional appliances; headgear; pre-banding devices, appliances or therapy; biteplanes; palatal expansion appliances; thumb or tongue appliances; positioners; active vertical correctors; or tooth guidance appliances.
  (e) lingual or clear brackets

(f) extractions or other oral surgical procedures for orthodontic purposes
(g) study models
(h) replacement of lost or broken appliances, bands, brackets or orthodontic retainers

Dental Covered Services Schedule 2

	MEMBER'S SERVICES	*MEMBER PAYS*
PREVENTATIVE		
D0120	Periodic oral evaluation	No Charge
D0140	Limited oral evaluation - problem focused	No Charge
D0150	Comprehensive oral evaluation – new or established patient	No Charge
D0170	Re-evaluation - limited, problem focused (established patient; non-post-operative visit	No Charge
D0180	Comprehensive periodontal evaluation – new or established patient	No Charge
D0210	Intraoral – complete series (includes bitewings)	No Charge
D0220	Intraoral – periapical first film	No Charge
D0230	Intraoral – periapical each additional film	No Charge
D0240	Intraoral - occlusal film	No Charge
D0250	Extraoral first film	No Charge
D0240	Extraoral each additional film	No Charge
D0270	Bitewing - single film	No Charge
D0272	Bitewings - two films	No Charge
D0274	Bitewings - four films	No Charge
D0277	Vertical bitewings – seven to eight films	No Charge
D0330	Panoramic film	No Charge
D0350	Oral/facial photographic images	No Charge
D0460	Pulp vitality tests	No Charge
D0470	Diagnostic casts	$15
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Charge
D0473	Accession of tissue, gross and microscopic examination preparation and transmission of written report	No Charge
D0474	Accession of tissue, gross and microscopic examination, assessment of surgical margins for presence of disease preparation and transmission of written report	No Charge

D1110	Prophylaxis - adult	No Charge
D1110	Prophylaxis – adult	
	(in addition to one allowed every six months)	$40
D1120	Prophylaxis - child	No Charge
D1120	Prophylaxis – child	
	(in addition to one allowed every six months)	$25
D1201	Topical application of fluoride (including prophylaxis) - child	No Charge
D1203	Topical application of fluoride (prophylaxis not included) - child	No Charge
D1204	Topical application of fluoride (prophylaxis not included) - adult	No Charge
D1205	Topical application of fluoride (including prophylaxis) - adult	No Charge
D1310	Nutrition counseling for control of dental disease	No Charge
D1330	Oral hygiene instructions	No Charge
D1351	Sealant - per tooth	$12
D1510	Space maintainer, fixed - unilateral	$55
D1515	Space maintainer, fixed - bilateral	$55
D1520	Space maintainer, removable - unilateral	$55
D1525	Space maintainer, removable - bilateral	$55
D1550	Re-cementation of space maintainer	$10
RESTORATIVE		
D2140	Amalgam - 1 surface, primary	$10
D2150	Amalgam - 2 surfaces, primary	$12
D2160	Amalgam - 3 surfaces, primary	$16
D2161	Amalgam - 4 or more surfaces, primary	$24
D2140	Amalgam - 1 surface, permanent	$18
D2150	Amalgam - 2 surfaces, permanent	$20
D2160	Amalgam - 3 surfaces, permanent	$22
D2161	Amalgam - 4 or more surfaces, permanent	$27
D2330	Resin-based composite - 1 surface, anterior	$20
D2331	Resin-based composite - 2 surfaces, anterior	$24
D2332	Resin-based composite - 3 surfaces, anterior	$40
D2335	Resin-based composite - 4 or more surfaces or	

	involving incisal angle, anterior	$50
D2390	Resin-based composite crown – anterior (primary)	$50
D2391	Resin-based composite – 1 surface, posterior (primary)	$45
D2392	Resin-based composite – 2 surfaces, posterior (primary)	$45
D2393	Resin-based composite – 3 surfaces, posterior (primary)	$55
D2394	Resin-based composite – 4 or more surfaces, posterior (primary)	$60
D2391	Resin-based composite – 1 surface, posterior (permanent)	$80
D2392	Resin-based composite – 2 surfaces, posterior (permanent)	$85
D2393	Resin-based composite – 3 surfaces, posterior (permanent)	$90
D2394	Resin-based composite – 4 or more surfaces, posterior (permanent)	$100
D2510	Inlay - metallic - one surfaces***	$225
D2520	Inlay - metallic - two surfaces***	$225
D2530	Inlay - metallic – three or more surfaces***	$225
D2542	Onlay - metallic - two surfaces***	$225
D2543	Onlay - metallic - three surfaces***	$225
D2544	Onlay - metallic - four or more surfaces***	$225
D2740	Crown - porcelain/ceramic substrate	$300
D2750	Crown - porcelain fused to high noble metal***	$225
D2751	Crown - porcelain fused to predominately base metal	$225
D2752	Crown - porcelain fused to noble metal***	$225
D2780	Crown - 3/4 cast high noble metal***	$225
D2781	Crown - 3/4 cast predominantly base metal	$225
D2782	Crown - 3/4 cast noble metal***	$225
D2783	Crown - 3/4 porcelain/ceramic	$225
D2790	Crown - full cast high noble metal***	$225
D2791	Crown - full cast predominantly base metal	$225
D2792	Crown - full cast noble metal***	$225
D2794	Crown - titanium	$225
D2910	Recement inlay, onlay, or partial coverage restoration	$10
D2915	Recement cast or prefabricated post and core	$10

******Dental copayments have an additional charge not to exceed the actual lab cost for precious and semi-precious metals.***

D2920	Recement crown	$10
D2930	Prefabricated stainless steel crown - primary tooth	$25
D2931	Prefabricated stainless steel crown - permanent tooth	$35
D2940	Sedative filling	No Charge
D2950	Core build up, including any pins***	$30
D2951	Pin retention, per tooth in addition to restoration***	$15
D2952	Cast post and core in addition to crown***	$75
D2953	Each additional cast post - same tooth***	$40
D2954	Prefabricated post and core in addition to crown	$55
D2955	Post removal (not in conjunction with endodontic therapy)	$10
D2970	Temporary crown (fractured tooth)	No Charge
	ENDODONTICS	
D3110	Pulp cap, direct (excluding final restoration)	$5
D3120	Pulp cap, indirect (excluding final restoration)	$5
D3220	Therapeutic pulpotomy (excluding final restoration – removal of pulp coronal to the denticemental junction and application of medicament)	$18
D3221	Pulp debridement, primary and permanent teeth	$18
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$25
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$25
D3310	Anterior (excluding final restoration)	$85
D3320	Bicuspid I (excluding final restoration)	$145
D3330	Molar (excluding final restoration)	$225
D3332	Incomplete endodontic therapy, inoperable, unrestoreble or fractured tooth	$85
D3346	Retreatment of previous root canal therapy - anterior	$170
D3347	Retreatment of previous root canal therapy - bicuspid	$245
D3348	Retreatment of previous root canal therapy - molar	$275

******Dental copayments have an additional charge not to exceed the actual lab cost for precious and semi-precious metals.***

D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$65
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	$65
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$65
D3410	Apicoectomy/periradicular surgery - anterior	$125
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$150
D3425	Apicoectomy/periradicular surgery - molar (first root)	$160
D3426	Apicoectomy/periradicular surgery – (each additional root)	$125
D3430	Retrograde filling - per root	$95
D3450	Root amputation - per root	$150
D3920	Hemisection (including any root removal), not including root canal therapy	$125

PERIODONTICS

D4210	Gingivectomy or gingivoplasty, four or more contiguous teeth or bounded teeth spaces - per quadrant	$100
D4211	Gingivectomy or gingivoplasty, one to three – contiguous teeth or bounded teeth spaces -per quadrant	$35
D4240	Gingival flap procedure, including root planning – four or more contiguous teeth or bounded teeth spaces – per quadrant	$275
D4241	Gingival flap procedure, including root planning – one to three contiguous teeth or bounded teeth spaces – per quadrant	$275
D4249	Clinical crown lengthening - hard tissue	$160
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces- per quadrant	$350
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or bounded teeth spaces - per quadrant	$350
D4270	Pedicle soft tissue graft procedure	$375

D4271	Free soft tissue graft (including donor site surgery)	$375
D4273	Subepithelial connective tissue graft procedures	$375
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$50
D4341	Periodontal scaling and root planing - four or more teeth- per quadrant	$40
D4342	Periodontal scaling and root planing – one to three teeth - per quadrant	$40
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$40
D4381	Localized delivery of chemotherapeutic agent via controlled release vehicle into diseased crevicular tissue, per tooth, by report	$60
D4910	Periodontal maintenance	$35
D4999	Periodontal charting for treatment planning or periodontal disease	No Charge

PROSTHODONTICS (Removable Dentures/Partials)

D5110	Complete denture - maxillary	$200
D5120	Complete denture - mandibular	$200
D5130	Immediate denture - maxillary	$200
D5140	Immediate denture - mandibular	$200
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$200
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$225
D5213	Maxillary partial denture - cast metal framework, resin denture bases (including any conventional clasps, rests and teeth)	$250
D5214	Mandibular partial denture - cast metal framework, resin denture base (including any clasps, rests and teeth)	$250
D5410	Adjust complete denture, maxillary	$15
D5411	Adjust complete denture, mandibular	$15
D5421	Adjust partial denture, maxillary	$15
D5422	Adjust partial denture, mandibular	$15

D5510	Repair broken complete denture base	$25
D5520	Replace missing or broken tooth (complete denture) - each tooth	$25
D5610	Repair resin denture base	$30
D5620	Repair cast framework	$35
D5630	Repair or replace broken clasp	$30
D5640	Replace broken teeth - per tooth	$35
D5650	Add tooth to existing partial denture	$35
D5660	Add clasp to existing partial denture	$35
D5710	Rebase complete maxillary denture	$100
D5711	Rebase complete mandibular denture	$100
D5720	Rebase maxillary partial denture	$100
D5721	Rebase mandibular partial denture	$100
D5730	Reline complete maxillary denture (chairside)	$45
D5731	Reline complete mandibular denture (chairside)	$45
D5740	Reline maxillary partial denture (chairside)	$45
D5741	Reline mandibular partial denture (chairside)	$45
D5750	Reline complete maxillary denture (laboratory)	$70
D5751	Reline complete mandibular denture (laboratory)	$70
D5760	Reline maxillary partial denture (laboratory)	$70
D5761	Reline mandibular partial denture (laboratory)	$70
D5810	Interim complete denture - maxillary	$100
D5811	Interim complete denture - mandibular	$100
D5820	Interim partial denture - maxillary	$70
D5821	Interim partial denture - mandibular	$70
D5850	Tissue conditioning - maxillary	$25
D5851	Tissue conditioning - mandibular	$25

PROSTHODONTICS (Fixed)

D6210	Pontic - cast high noble metal***	$225
D6211	Pontic - cast predominantly base metal	$225
D6212	Pontic - cast noble metal***	$225

****Dental copayments have an additional charge not to exceed the actual lab cost for precious and semi-precious metals.***

D6214	Pontic - titanium	$225
D6240	Pontic - porcelain fused to high noble metal***	$225
D6241	Pontic - porcelain fused to predominantly base metal***	$225
D6242	Pontic - porcelain fused to noble metal***	$225
06245	Pontic - porcelain/ceramic	$225
D6750	Crown - porcelain fused to high metal***	$225
D6751	Crown - porcelain fused to predominantly base metal	$225
D6752	Crown - porcelain fused to noble metal ***	$225
D6780	Crown - 3/4 cast high noble metal***	$225
D6781	Crown - 3/4 cast predominantly base metal	$225
D6782	Crown - 3/4 cast noble metal***	$225
D6790	Crown - full cast high noble metal***	$225
D6791	Crown - full cast predominantly base metal	$225
D6792	Crown - full cast noble metal***	$225
D6794	Crown - titanium	$225
D6930	Recement fixed partial denture	No Charge
D6970	Cast post and core in addition to fixed partial denture retainer***	$70
D6971	Cast post as part of fixed partial denture retainer***	$70
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$55
D6973	Core build up for retainer, including any pins***	$30
D6976	Each additional cast post - same tooth***	$40
D6977	Each additional prefabricated post - same tooth	$20

ORAL SURGERY

D7111	Extraction, coronal remnants – deciduous tooth	$15
D7140	Extraction – erupted tooth or exposed root (evaluation and/or forceps removal)	$15
D7210	Surgical removal of erupted tooth requiring evaluation of mucoperiosteal flap and removal of bone and/or section of tooth	$40
D7220	Removal of impacted tooth - soft tissue	$60

******Dental copayments have an additional charge not to exceed the actual lab cost for precious and semi-precious metals.***

D7230	Removal of impacted tooth - partial bony	$80
D7240	Removal of impacted tooth - completely bony	$125
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$150
D7250	Surgical removal of residual tooth roots (cutting procedure)	$50
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110
D7280	Surgical access exposure of an unerupted tooth	$175
D7285	Biopsy of oral tissue – hard (bone, tooth)	$60
D7286	Biopsy of oral tissue – soft (all others)	$60
D7310	Alveoplasty in conjunction with extractions - per quadrant	$55
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces – per quadrant	$18
D7320	Alveoplasty not in conjunction with extractions - per quadrant	$70
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$23
D7510	Incision and drainage of abscess - intraoral soft tissue	No Charge
D7511	Incision and drainage of abscess - intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	No Charge
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$45
D7963	Frenuloplasty	$45
D7971	Excision of pericoronal gingival	$60
D8050	Removable and/or Fixed Appliance(s)Insertion for Interceptive Treatment, primary dentition	$725
D8060	Removable and/or Fixed Appliance(s)Insertion for Interceptive Treatment, transitional dentition	$725
D8080	Comprehensive orthodontic treatment transitional dentition	$1,950
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,950
D8090	Comprehensive orthodontic treatment of	

	the adult dentition	$2,250
D8660	Pre-orthodontic treatment visit	No Charge
D8670	Periodontic orthodontic treatment visit (as part of contract)	No Charge
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer (s))	$250
D8999	Start-up fee (including exam, beginning records, x-rays, tracings, photo and models) construction and placement of retainer (s))	$250
D8999	Post-treatment records	$150
D8999	Monthly orthodontic fee (for comprehensive treatment beyond 24 months)	$35
D9110	Palliative treatment (emergency) of dental pain-minor procedure	$20
D9210	Local anesthesia not in conjunction with operative or surgical procedures	No Charge
D9211	Regional block anesthesia	No Charge
D9215	Local anesthesia	No Charge
D9220	Deep sedation/general anesthesia – first 30 minutes	$125
D9221	Deep sedation/general anesthesia – each additional 15 minutes	$60
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	$125
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	$60
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment	No Charge
D9430	Office visit for observation (during regularly scheduled hours) no other services performed	No Charge
D9440	Office visit - after regularly scheduled hours	$20
D9630	Other drugs and/or medicaments by reports	$15
D9910	Application of desensitizing medicament	$15
D9940	Occlusal guard by report	$100

D9942	Repair and/or reline of occlusal guard	$45
D9951	Occlusal adjustment - limited	No Charge
D9952	Occlusal adjustment - complete	$75
D9999	Record transfer - transfer of all materials with or without an X-ray	$15
MATERIALS UPGRADES FOR NON-ELECTIVE DENTAL SERVICES (in addition to copayment for services)		
D2750	Porcelain on molars	$75
D2999	Noble or high noble metal for crowns – lab cost	Lab Cost
D2740	Lucite-reinforced pressed crown/Empress	$300 + copayment[1]
D2750	Gold composite reinforced crown/Catek	$300 + copayment[1]
D5110	Comfort Flex (complete upper denture) acetyl resin homopolymer	$400 + copayment[1]
D5120	Comfort Flex (complete lower denture) acetyl resin homopolymer	$400 + copayment[1]
D5211	Comfort Flex (upper partial denture) acetyl resin homopolymer	$425 + copayment[1]
D5212	Comfort Flex (lower partial denture) acetyl resin homopolymer	$425 + copayment[1]
COSMETIC DENTISTRY SERVICES (elective services)		
D2330	Resin based-composite, one surface anterior	$80
D2331	Resin based-composite, two surfaces anterior	$95
D2332	Resin based-composite, three surfaces anterior	$105
D2335	Resin based-composite, four or more surfaces or involving incisal angle (anterior)	$125
D2391	Resin based-composite, one surface posterior	$85
D2392	Resin based-composite, two surfaces posterior	$100
D2393	Resin based-composite, three surfaces posterior	$110
D2394	Resin based-composite, four or more surfaces posterior	$130
D2740	Leucite-reinforced pressed crown/Empress	$700
D2962	Labial veneer/porcelain laminate	$450
D5110	Comfort Flex (complete upper denture) acetyl resin homopolymer	$650

[1] ***For the applicable copayment, please see the corresponding procedure code within this Dental Schedule***

D5120	Comfort Flex (complete lower denture) acetyl resin homopolymer	$650
D5211	Comfort Flex (upper partial denture) acetyl resin homopolymer	$725
D5212	Comfort Flex (lower partial denture) acetyl resin homopolymer	$725
D9972	External bleaching – per arch	$125

How to File a claim for Dental Care services?

In most cases your Primary Care General Dentist will submit your claims to Health Net Dental. To file a claim you may have, please send us a letter or complete a Health Net Dental claim form. If you need a claim form, go online to www.healthnet.com or contact the Customer Service Department of Health Net Dental at **1-800-880-8113** (TDD/TTY **1-800-880-3165**), Monday-Friday, 6:00 a.m. to 6:00 p.m. Interpreter Services are available by calling our Customer Service Department.

Attach your itemized bill to the claim form or letter. Mail the itemized bill , completed claim form or letter to:

Health Net Dental
P.O. Box 30920
Laguna Hills, CA 92654-0920

We will mail you notification of our determination on your claim within 72hours of receipt of your claim. If a reimbursement is due to you, a check will be mailed within 30 days of receipt of your claim.

Reimbursement For Emergency Dental Care

If the Member sees a dentist other than his/her Primary Care General Dentist for Emergency Dental Care, the dentist may ask for payment at the time the service is provided. If the Member pays a bill for covered Emergency Dental Care, the Member should send in a copy of the paid bill to:

Health Net Dental
P.O. Box 30920
Laguna Hills, CA 92654-0920

All such claims must be sent to Health Net Dental to be considered for payment. Please include either the dentist's completed claim form or a separate sheet of paper, if a form is unavailable, that includes the following information:

- Name, address, ID number, and group number from the Member's identification card.
- Name and address of the dentist who provided the service (unless stated on the bill).
- An explanation of the condition that made emergency treatment necessary.
- An itemized receipt that specifies the Covered Services provided.

If additional information is needed, the Member will be advised in writing. If all or part of the claim is denied, the Member will receive written notice of the decision within 30 days including:

- The reason for denial.
- Reference to the pertinent Evidence of Coverage provision(s) on which the denial is based.
- Notice of the right to request reconsideration of the denial and an explanation of the appeal process.

If the member receives Emergency Dental Care from a dentist that is not the Member's Primary Care General Dentist, the member should return to his or her Primary Care General Dentist for follow-up care.

Non-Qualifying Services for Emergency Dental Care

Emergency Dental Care does not include these services:

- Normal diagnostic and preventive services.
- Permanent restorative and prosthetic services.
- Complete endodontic services.
- Complete periodontic services.
- Orthodontic services.
- Oral surgery for conditions that are not severe.
- Other services that are not required for Emergency Dental Care.

QUESTIONS?

For up-to-date Primary Care General Dentist information or to obtain authorization to receive services, please contact the Customer Service Department of Health Net Dental at **1-800-880-8113** (TDD/TTY **1-800-880-3165**), Monday-Friday, 6:00 a.m. to 6:00 p.m. Interpreter Services are available by calling our Customer Service Department.. Or visit the Health Net Vision web site at www.healthnet.com for a list of Health Net Dental participating providers in your area.

Dental Services Package 2 (DPPO)

NOTE: ***All Health Net Seniority Plus members have Medicare covered Dental benefits. Only Health Net members who have purchased the Optional Supplemental Benefit Package 2 have non-Medicare covered preventive PPO Dental benefits. Please see Section 4 under "Extra benefits you can buy (these are called "optional supplemental benefits")" for copayment and benefit information.***

Dental services are administered by Health Net Dental. Dental services are covered as shown in Section 4 of this Evidence of Coverage under "Dental services." You can see any licensed dentist to receive covered dental services. However, your cost shares are higher when you receive covered services from non-plan providers than from plan providers. Dental services are offered through Health Net Dental network providers. Health Net Dental providers are listed in your provider directory. Please contact Health Net Dental customer service department for a list of plan providers at the toll-free number **1-800-880-8113** (or TTY **1-800-880-3165**), Monday through Friday, 6:00 a.m. to 6:00 p.m., except holidays.

What Health Net Dental services are covered?

Preventive services listed below from plan and non-plan providers are covered. See Section 4 of this Evidence of Coverage under "Dental services" for deductible, copayment, coinsurance and benefit maximums information.

- Periodic Oral examinations (covered as a separate benefit only if no other service was done during the visit other than x-rays)
- Bitewing x-rays
- Panoramic x-rays
- Dental prophylaxis (cleanings)

What Health Net Dental services are not covered by Seniority Plus?

In addition to any exclusions or limitations described in Section 5 of this Evidence of Coverage, the following items and services are not covered by Health Net Seniority Plus as part of the routine dental benefits provided by Health Net Dental.

General Dental Limitations:

1. Oral examinations covered as a separate benefit only if no other service was done during the visit other than x-rays. Limited to 1 times per year, one time every 12 months.
2. Complete series or panorex radiographs limited to one time per 36 months (multi-year benefits may not be available in subsequent years).
3. Bitewing radiographs limited to 1 series of films per year.
4. Extraoral radiographs limited to 1 films per year.
5. Dental prophylaxis limited to 1 times per year, once every 12 months.

General Dental Exclusions:

1. Any service or supply not defined within the Evidence of Coverage booklet.
2. Any procedure started before the effective date or after the termination date of the covered person's insurance.
3. Prescribed drugs, medications or analgesia; training in or supplies used for dietary counseling, oral hygiene or plaque control; nitrous oxide or sterilization charges; pulp caps or medicaments.
4. Treatment by anyone other than a dentist, except where performed by a duly qualified hygienist under the direction of a dentist.
5. Dental services, which do not have uniform professional endorsement by the American Dental Association.
6. Expenses resulting from any intentionally self-inflicted injury or sickness.
7. Charges for professional services rendered by any individual who is related to the covered person by blood or marriage.
8. Any expenses compensable under any Workers' Compensation law or act, Employers' Liability law or by any governmental program, law or agency.
9. Care rendered within any facility of, or provided by: (1) the United States Government or any agency thereof or (2) any hospital or institution, which does not require the covered person to pay for such services in the absence of insurance.
10. Treatment of congenital malfunctions or malformations.
11. .Cosmetic treatment (treatment primarily to enhance or change appearance) whether or not for psychological or emotional reasons.

How do I file a Health Net Dental claim?

When you see a non-plan dentist, you will have to file a claim with Health Net Dental. Health Net Dental will pay your provider its share of the bill for any covered services that are determined to have been Medically Necessary and let you know what, if anything, you must pay your provider. Please call or write to the Health Net Dental customer service department for a claim form and claim filing instructions at the toll-free number **1-800-880-8113** (or TTY **1-800-880-3165**), Monday through Friday, 6:00 a.m. to 6:00 p.m., except holidays. The bill should be submitted to the following address:

Health Net Dental Claims Department
Post Office Box 30930
Laguna Hills, CA 92654-0930

Section 17 Definitions of some words used in this booklet

For the terms listed below, this section either gives a definition or directs you to a place in this booklet that explains the term

Acupuncture Services -- Are services rendered or made available to a Member by an acupuncturist for treatment or diagnosis of Neuromusculo-skeletal Disorders, Nausea and Pain. Acupuncture Services include services rendered by an acupuncturist for the treatment of carpal tunnel syndrome, headaches, menstrual cramps, osteoarthritis, stroke rehabilitation and tennis elbow. Acupuncture Services do not include any other services, including services for treatment of asthma or addiction (including, but not limited to, drugs, alcohol, nicotine addiction or smoking cessation).

Acute (Mental Health Care and Chemical Dependency) -- Sudden onset or abrupt change of a mental health condition requiring prompt attention, but which is of limited duration, as determined by MHN.

Aesthetic Dentistry -- Dental services and supplies which Health Net Dental determines to be performed for cosmetic purposes. These services and supplies are not covered under the dental plan.

American Specialty Health Plans of California, Inc., (ASH Plans) -- Is a specialized health care service plan contracting with Health Net to arrange the delivery of Chiropractic and Acupuncture Services through a network of ASH Contracted Chiropractors and ASH Contracted Acupuncturists.

Appeal – A type of complaint you make when you want us to reconsider and change a decision we have made about what services are covered for you or what we will pay for a service. Sections 10 and 11 explain about appeals, including the process involved in making an appeal.

ASH Contracted Acupuncturist -- Means an acupuncturist who is duly licensed to practice acupuncture in California and who has entered into an agreement with American Specialty Health Plans of California, Inc. (ASH Plans) to provide covered services to Members.

ASH Contracted Chiropractor -- Means a chiropractor who is duly licensed to practice chiropractic in California and who has entered into an agreement with American Specialty Health Plans of California, Inc. (ASH Plans) to provide covered services to Members.

Authorization (Mental Health Care and Chemical Dependency) -- A decision in writing by MHNs Medical Director or his/her designee that the services that a Member will receive or has received under a particular Plan meet MHN clinical criteria. Requests for Authorization will be denied if not Medically Necessary, if in conflict with MHNs policies or are otherwise not covered under the Plan. The actual payment of benefits is determined by eligibility at the time services were rendered, Authorization, and available benefits.

Behavioral Health Administrator -- Is a specialized health care service plan which contracts with Health Net to underwrite and administer delivery of Mental Disorders and Chemical Dependency services through a network of Contracted Mental Health Practitioners and Contracted Mental Health Facilities. Health Net has contracted with Managed Health Network (MHN) to be the Behavioral Health Administrator.

Benefit period – For both Seniority Plus and Original Medicare, a Benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A Benefit period *begins* on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The Benefit period *ends* when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one Benefit period has ended, a new Benefit period begins. There is no limit to the number of Benefit periods you can have. The type of care you actually receive during the stay determines whether you are considered to be an inpatient for SNF stays, but not for hospital stays.

You are an inpatient in a SNF only if your care in the SNF meets certain skilled level of care standards. Specifically, in order to have been an inpatient while in a SNF, you must need daily skilled nursing or skilled rehabilitation care, or both. (Section 7 tells what is meant by skilled care.)

Generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital (the type of care you actually receive in the hospital does not determine whether you are considered to be an inpatient in the hospital).

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are not available until after the patent on the brand name drug has expired.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that runs the Medicare program. Section 1 tells how you can contact CMS.

Chemical Dependency -- Is psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care and treatment.

Chemical Dependency Care Facility -- Is a Hospital, residential treatment center, structured outpatient program, day treatment or partial hospitalization program or other mental health care facility that is licensed to provide Chemical Dependency detoxification services or rehabilitation services.

Chiropractic Appliances -- Are support type devices prescribed by a Seniority Plus Contracted Chiropractor specifically for the treatment of a Neuromusculo-skeletal Disorder. The devices covered are limited to elbow supports, back (thoracic) supports, cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar supports, lumbar cushions, orthotics, wrist supports, rib belts, and home traction units (cervical or lumbar), ankle braces, knee braces, rib supports and wrist braces.

Chiropractic services -- Are services rendered or made available to a Member by a chiropractor for treatment or diagnosis of Neuromuscolo-skeletal Disorders.

Contracted Eyewear Dispenser -- Is a licensed retail dispenser of Eyewear that has a contract in effect with Health Net Vision.

Contracted Dentist/Dental Facility -- A dentist or dental facility licensed to provide Covered Services, and that has a contract in effect with Health Net Dental to furnish care to Members who have enrolled in Health Net's Supplemental Benefit Buy-up Option at the time care is provided to a Member. The names of Contracted Dentists and/or dental facilities can be found in Health Net Dental's Contracted Dentist Directory. The names of Contracted Dentists and/or dental facilities and their locations and hours of practice may also be obtained by contacting Health Net Dental's Customer Service Department. This dental Plan does not guarantee the initial or continued availability of any particular Contracted Dentist.

Contracted Mental Health Facility -- Is a Hospital, residential treatment center, structured outpatient program, day treatment, partial hospitalization program or other mental health care facility that has signed a service contract with MHN, to provide Mental Disorder and Chemical Dependency benefits. This facility must be licensed by the state of California to provide Acute or intensive psychiatric care, detoxification services or Chemical Dependency rehabilitation services.

Contracted Mental Health Professional -- Is a Physician or other professional (excluding Licensed Marriage and Family Therapists (LMFTs) who is licensed by the state of California to provide mental health care. The Contracted Mental Health Professional (excluding LMFTs) must have a service contract with MHN to provide Mental Disorder and Chemical Dependency rehabilitation services.

Coverage Determination - The plan sponsor has made a coverage determination when it makes a decision about the prescription drug benefits you can receive under the plan, and the amount that you must pay for a drug.

Covered services -- The general term we use in this booklet to mean all of the health care services and supplies that are covered by Seniority Plus. Covered services are listed in the Benefits Chart in Section 4.

Creditable Coverage – Coverage that is at least as good as the standard Medicare prescription drug coverage.

Custodial Care -- Care rendered to a Member who meets any of the following conditions:

- Disabled mentally or physically and such disability is expected to continue and be prolonged.
- Requires a protected, monitored, or controlled environment whether in an institution or in a home.
- Requires assistance to support the essentials of daily living.
- Not under active and specific psychiatric treatment that will reduce the disability to the extent necessary to enable the Member to function outside the protected, monitored, or controlled environment.

A determination that Custodial Care is required is not precluded by the fact that a Member is under the care of a supervising or attending physician or other participating practitioner and that services are being ordered and prescribed to support and generally maintain the Member's condition, provide for the Member's comfort, or ensure the manageability of the Member.

Disenroll or Disenrollment – The process of ending your membership in Seniority Plus. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 13 tells about Disenrollment.

Durable Medical Equipment – Equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. A person normally needs this kind of equipment only when ill or injured. It can be used in the home. Examples of Durable Medical Equipment include wheelchairs, hospital beds, or equipment that supplies a person with oxygen.

Emergency Care – Covered services that are 1) furnished by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition. Section 3 tells about emergency services.

Evidence of Coverage and Disclosure Information – This document along with your enrollment form and any amendments, which explains your covered services, defines our obligations, and explains your rights and responsibilities as a Member of Seniority Plus.

Exception– A type of coverage determination that, if approved, allows you to obtain a drug that is not on our formulary (a formulary exception), or receive a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if we require you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Experimental -- Medical care that is essentially investigatory or an unproven procedure or treatment regimen that does not meet the generally accepted standards of usual professional medical or mental health practice in the general professional community, unless otherwise deemed appropriate by an Independent Medical Review organization.

Eyewear -- Is either Eyeglasses or Contact Lenses.

Formulary – A list of covered drugs provided by the plan.

Generic Drug – A prescription drug that has the same active-ingredient formula as a brand name drug. Generic drugs usually cost less than brand name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand name drugs.

Grievance – A type of complaint you make about us or one of our plan providers, including a complaint concerning the quality of your care. This type of complaint does not involve payment or coverage disputes. See Section 10 for more information about grievances.

Inpatient Care– Health care that you get when you are admitted to a hospital.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you don't join a plan when you're first able. You pay this higher amount as long as you have Medicare. There are some exceptions. If you do not have creditable prescription drug coverage, you will have to pay a penalty in addition to your monthly plan premium.

Medical Group – A group of primary care and specialty care physicians, organized as a legal entity, which has an agreement in effect with Health Net to furnish medical care to Seniority Plus members.

Medically necessary– Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of you or your doctor.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Organization – A public or private organization licensed by the State as a risk-bearing entity that is under contract with the Centers for Medicare & Medicaid Services (CMS) to provide covered services. Medicare Advantage Organizations can offer one or more Medicare Advantage Plans. Health Net is a Medicare Advantage Organization.

Medicare Advantage Plan – A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at a uniform premium and uniform level of cost-sharing to all people with Medicare who live in the Service Area covered by the Plan. A Medicare Advantage Organization may offer more than one plan in the same Service Area. Seniority Plus is a Medicare Advantage Plan.

Medicare Allowable Cost (MAC) – The maximum amount Medicare will reimburse for a particular covered service

Medicare Cost Plan – *Cost plan* means a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare Managed Care Plan – Means a Medicare Advantage HMO, Medicare Cost Plan, or Medicare Advantage PPO.

Medicare Prescription Drug Coverage – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part B.

"Medigap" (Medicare Supplement Insurance) policy – Many people who get their Medicare through Original Medicare buy "Medigap" or Medicare Supplement Insurance policies to fill "gaps" in Original Medicare coverage.

Member (Member of Seniority Plus, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in Seniority Plus, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member services – A department within Health Net responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 1 for information about how to contact Member Services.

Mental Disorders -- Are nervous or mental conditions that meet all of the following criteria:

- It is a clinically significant behavioral or psychological syndrome or pattern;
- It is associated with a painful symptom, such as distress;
- It impairs a patient's ability to function in one or more major life activities; or
- It is a condition listed as an Axis I Disorder (excluding V Codes) in the most recent edition of the DSM by the American Psychiatric Association.

Network Dentist -- A licensed dentist who has signed an agreement with Health Net Dental to provide general dentistry or specialty care services to Members who are enrolled in Health Net's Supplemental Benefit Buy-up Option. This term is used to refer to both primary care general dentists and network specialty dentists.

Network Pharmacy – A network pharmacy is a pharmacy where members of our Plan can receive covered prescription drug benefits. We call them "network pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Non-plan Provider or Non-plan Facility – A provider or facility that we have not arranged with to coordinate or provide covered services to members of Seniority Plus. Non-plan providers are providers that are not employed, owned, or operated by Health Net and are not under contract to deliver covered services to you. As explained in this booklet, most services you get from non-plan providers are not covered by Health Net or Original Medicare.

Optional Supplemental Benefits – Non-Medicare covered benefits that can be purchased for an additional premium and are not included in your package of benefits. If you choose to have optional supplemental benefits, you may have to pay an additional premium. Members of Seniority Plus must voluntarily elect Optional Supplemental Benefits in order to get them.

Optometrist -- Is a licensed doctor of optometry (O.D.).

Organization Determination - The MA organization has made an organization determination when it, or one of its providers, makes a decision about MA services or payment that you believe you should receive.

Original Medicare – Some people call it "traditional Medicare" or "fee-for-service" Medicare. Original Medicare is the way most people get their Medicare Part A and Part B health care. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider

who accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that we have not arranged with to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of Coverage, most services you get from non-network pharmacies are not covered by our Plan unless certain conditions apply. See Section 1.

Part D – The voluntary Prescription Drug Benefit Program. (For ease of reference, we will refer to the new prescription drug benefit program as Part D.)

Part D Drugs – Any drug that can be covered under a Medicare Prescription Drug Plan. Generally, any drug not specifically excluded under Medicare drug coverage is considered a Part D Drug.

Plan Provider – **"Provider"** is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**plan providers**" when they have an agreement with Seniority Plus to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of Seniority Plus. Health Net pays plan providers based on the agreements it has with the providers.

Primary Care Physician (PCP) – A health care professional who is trained to give you basic care. Your PCP is responsible for providing or authorizing covered services while you are a Plan Member. Section 2 tells more about PCPs.

Prior Authorization – Approval in advance to get services. Some in-network services are covered only if your doctor or other plan provider gets "prior authorization" from Health Net or your Medical Group. Covered services that need prior authorization are marked in the Benefits Chart. . If your plan offers Part D drugs, certain drugs may require prior authorization. Check with your plan.

Prudent Layperson -- A person who is without clinical training and who draws upon their practical experience when making a decision regarding whether emergency treatment is needed. They are considered to have acted "reasonably" if other similarly situated laypersons would have believed, on the basis of observing the clinical symptoms at hand, that emergency treatment was necessary.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts who are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by doctors in inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private fee-for-service plans and ambulatory surgical centers. See Section 1 for information about how to contact the QIO in your state and Section 10 for information about making complaints to the QIO.

Referral – Your PCP's or his/her Medical Group or IPA's approval for you to see a certain plan specialist or to receive certain covered services from plan providers.

Rehabilitation Services – These services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy that are provided under the direction of a plan provider. See Section 7 for more information.

Serious Chronic Condition -- A condition due to a disease, illness or other Mental Disorder that is serious in nature, persists without full cure or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration.

Serious Emotional Disturbances of a Child -- Is when a child under the age of 18 has one or more Mental Disorders identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or a developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. In addition, the child must meet one or more of the following:

- As a result of the Mental Disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships or ability to function in the community; and either (i) the child is at risk of removal from home or has already been removed from the home or (ii) the Mental Disorder and impairments have been present for more than six months or are likely to continue for more than one year;
- The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a Mental Disorder; and/or
- The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Service Area – Section 2 tells about Seniority Plus's service area. "Service Area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare Health Plan.

Severe Mental Illness -- Includes schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorders, pervasive developmental disorder (including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified to include Atypical Autism, in accordance with the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders), autism, anorexia nervosa and bulimia nervosa.

Special Needs Plan – A special type of plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Treatment Plan -- A detailed description of the healthcare service, treatment, or supply being rendered or expected to be rendered to a Member. The Treatment Plan must include, but is not limited to:

- A diagnosis.
- Reports of pertinent prior treatment, medical, family, social and work history and/or any diagnostic tests, anticipated frequency and duration of medications and consultations.
- A description of the specific goals of treatment.

- Prognosis and proposed treatment and modality.

Usual and Customary Reasonable Fee (UCR) -- The Usual and Customary fee is defined as the charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical service area.

Urgently needed care – Section 3 explains about urgently needed services. These are different from emergency services.

For more information, please contact us at:

Health Net Seniority Plus
Post Office Box 10198
Van Nuys, California 91410-0198

Member Services Department
1.800.275.4737
Our office hours are from 8:00 a.m. to 8:00 p.m., 7 days a week.

Telecommunications Device for the Deaf
1.800.929.9955
Our office hours are from 8:00 a.m. to 8:00 p.m., 7 days a week.

Para los que hablan español
1.800.275.4737
Nuestras horas de negocio son de las de 8:00am a 8:00pm, siete días a la semana.

Dispositivo de telecomunicaciones para las personas con impedimentos auditivos
1.800.929.9955
Nuestras horas de negocio son de las de 8:00am a 8:00pm, siete días a la semana.
WWW.HEALTHNET.COM.

FEDERAL COURT PROOF OF SERVICE
Freda Sussman v. Health Net of California, Inc. - File No. 25713-217

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

At the time of service, I was over 18 years of age and not a party to the action. My business address is 221 North Figueroa Street, Suite 1200, Los Angeles, California 90012. I am employed in the office of a member of the bar of this Court at whose direction the service was made.

On March 10, 2008, I served the following document(s): **REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF HEALTH NET OF CALIFORNIA, INC.'S MOTION TO DISMISS ACTION, PURSUANT TO FEDERAL RULES OF CIVIL PROCEDURE 12(b)(1) AND 12(b)(6); DECLARATION OF MARCI ARMIN IN SUPPORT THEREOF.**

I served the documents on the following persons at the following addresses (including fax numbers and e-mail addresses, if applicable): **SEE ATTACHED SERVICE LIST.**

The documents were served by the following means:

[X] (BY U.S. MAIL) I enclosed the documents in a sealed envelope or package addressed to the persons at the addresses listed above and I deposited the sealed envelope or package with the U.S. Postal Service, with the postage fully prepaid.

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Executed on March 10, 2008, at Los Angeles, California.

MARCIA COX

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